Town Assistance Instruction Sheet

☐ ***Read.*** Read these instructions and the application carefully. Answer all questions.

☐ ***Application.*** Fill out application completely. If information does not apply to your situation, indicate this by writing "N/A" in the appropriate spaces on the application form.

☐ ***Document emergency.*** Town Assistance is an emergency assistance program and you must document the emergency you are facing. For example, you must provide a shut-off notice (for electricity), a foreclosure notice, notice to quit, or demand for rent (for rental or mortgage assistance) to qualify for assistance under this program. Some emergency situations are difficult to document (such as the need for food, a family or individual facing homelessness, or fuel for heat) and are handled on a case-by-case basis.

☐ ***Relatives must assist, if possible.*** *New Hampshire State Law* provides that in *certain cases, close relatives may be liable to provide you support*. See: Title XII, Chapter 165:19 of Revised New Hampshire Statutes Annotated (Liability for Support). Be certain to provide information about your relatives on the application.

☐ ***Document rent/mortgage expense.*** Have your landlord complete the Rental Verification Form completely. This form is part of the application. Homeowners: provide a current mortgage statement. *New Hampshire State Law* provides that towns *may place a lien on real property for assistance granted to property owners.* See: Title XII, Chapter 165:28 of Revised New Hampshire Statutes Annotated (Liens on Real Property).

☐ ***Sign and date application.*** Sign and date the application where indicated. If you are married, your spouse must also sign.

☐ ***Schedule an appointment.*** Call the following number to schedule an appointment;

- Charlestown: (603 826 5266

☐ ***Document income.*** Gather documentation on income during the past 30-day period for all members of your household (pay stubs, statement from employer indicating wages, statement of benefits from state/federal sources, etc.). *Bring this documentation to your appointment.*

☐ ***Document assets.*** Gather documentation on assets for all members of your household (checking/savings account statements, cash on hand, child support payments, vehicle registrations, retirement accounts, etc.). Also, gather documentation on any state, local, or federal benefits or programs that you are receiving (fuel assistance, food stamps, WIC, Section 8 housing, or other benefits). *Bring this documentation to your appointment.*

☐ ***Document basic living expenses.*** Gather documentation on basic living expenses for all members of your household during the past 30-day period (electric bills, Rental Verification Form, heating expenses, or other proof of basic living expenses). *Bring this documentation to your appointment.*

☐ ***Identification.*** Gather identification materials for all members of your household (photo identification is preferable for adults, birth certificates or social security cards for children are acceptable). *Bring this documentation to your appointment.*

☐ ***Medication assistance.*** If you are requesting medication assistance, have your medical provider fill out the Medication Expense Verification Form. *Bring this documentation to your appointment.*

☐ ***Cancellations and other concerns.*** Call the number listed above if you cannot keep your appointment so that other applicants can have the opportunity to meet with the Town Welfare Administrator.

- **Failure to read these instructions and supply the necessary documentation may cause a delay in processing your application.**
- **Do not turn in the application (or any documentation) before your scheduled appointment.**

Charlestown Department of Health & Human Services
P.O. Box 385 • Charlestown, NH 03603
TEL # 1-603-826-5266 FAX # 603-826-5181

NOTICE OF RIGHTS OF ANYONE RECEIVING ASSISTANCE FROM THE MUNICIPALITY OF CHARLESTOWN, NH

You have the following rights:

1. You have a right to make a written application for assistance, even if the welfare officer tells you that you are not eligible.

2. You have a right to receive a prompt written decision telling you whether or not you will receive assistance each time you apply for assistance.

3. You have a right to have in writing the reason why you have been denied assistance or have been given only some of the assistance you requested.

4. You have a right to appeal any decision you do not agree with. You must appeal within five (5) working days after you received your decision.

5. You have a right to have a hearing to present your case.

6. You have a right have your assistance continued if you are already receiving assistance when you request a fair hearing.

7. You have a right to review the information in your file before your hearing.

8. You have a right to see the guidelines used by the welfare officer in making decisions on your application.

9. You have a right to be given a written notice of conditions before you are suspended from receiving assistance for failing to obey the guidelines.

10. You have a right to refuse to participate in municipal workfare program or to conduct a job search if you must care for a child under the age of five (5), if you are disabled or ill, or if you must take care of a member of your family who is disabled or ill.

I/we have read and understand the rights set forth in this notice. I/we have been given a copy of this notice.

_____ _____

Applicant's signature Date

_____ _____

Co-applicant's signature Date

_____ _____

Welfare Officials signature Date

Charlestown Department of Health & Human Services
P.O. Box 385 • Charlestown, NH 03603
Phone (603) 826-5266 • Fax (603) 826-5181

9. Certifications and Signatures

I understand that if I receive assistance from the municipality I may be required to participate in the welfare work ("workfare") program. (RSA 165:31)

I understand that I may be required to repay any assistance provided, after deduction of the value of workfare hours I have completed, if I am returned to an income status, which enables me to reimburse without financial hardship. (RSA 165:20-b).

I understand that if I am assisted the municipality may place a lien against any real property, which I own. (RSA 165:28)

I hereby certify that if I have a lawsuit, worker's compensation claim, or aid from any other social service agency now pending, I have listed these in this application. I further agree to notify the Welfare Official immediately upon receipt of any money from or upon the settlement of such claim. I understand that if I am assisted, the municipality may place a lien against any property settlement or civil judgment for personal injuries, which I receive within six years of receiving municipal assistance. (RSA 165-28a)

I hereby certify that the information I have provided on this application is complete to the best of my knowledge and belief and provides a true summary of my income, assets and needs. I understand I may be required to provide documents and/or other forms of verification to prove the information requested on this application. I hereby certify that all information I will provide in response to questions asked by the welfare official is true and complete to the best of my knowledge and belief. I understand that if I knowingly give false information or withhold information related to my receipt of assistance, now or in the future, I may be prosecuted for the crime of Un-sworn Falsification (RSA 641:3)

I understand that if I obtain a job after the municipality assists me, and I later quit the job without good cause, I may be ineligible for local assistance from the municipality and any other New Hampshire municipality for a period of up to ninety days. (RSA 165:1-d)

I understand that if I am a recipient of Temporary Assistance for Needy Families (TANF) cash benefits and I fail to comply with TANF regulations, leading to a sanction and loss of income, the municipality may, under certain circumstances, disregard this decrease in my income. (RSA 165:1-e)

_____ _____

Applicant Signature *Date*

_____ _____

Spouse or Co-applicant Signature *Date*

_____ _____

Signature of person completing form (if not applicant) *Date*

Town of Charlestown, New Hampshire
Health and Human Services

GENERAL ASSISTANCE PROGRAM

The Town of Charlestown provides financial and resource assistance for eligible applicants who are struggling to meet their basic needs and who are facing a threat to their health or safety as a result.

These are *some* examples of situations in which you *may* be eligible for assistance:

You are at risk of losing or have lost your residence
You are at risk of losing or have lost necessary utilities
You don't have enough food
You don't have enough fuel to heat your home or cook food
You don't have income due to being unemployed or disabled

You have the right to apply for General Assistance at any time for any reason. Your eligibility for General Assistance is determined according to whether or not your allowed expenses exceed your income. You must provide specific information and documentation in order to have your application evaluated for eligibility. If you fail to comply with specified conditions, you may be found ineligible for assistance. Therefore, please read this application carefully. Complete it as best you can and ask questions if you have difficulty understanding any part of this application.

If you have questions, please contact the Welfare Administrator. The Charlestown Health and Human Services office is open each Tuesday and Thursday 8:30-1:00, and you can call 826-5266 during these hours. ~~To reach the Welfare Administrator outside of these hours, please call 1-800-894-8400.~~

I have read the application for General Assistance with the Town of Charlestown, NH, and I acknowledge that I understand its contents. I acknowledge that I have received and understand the Notice of Rights and Responsibilities.

_____ _____

Signature of Applicant(s) Date

RENTAL VERIFICATION FORM

THIS FORM MUST BE COMPLETED BY THE LANDLORD

Tenant's Name: _____ Date: _____

Address: _____
(Number/Street) (Apt. #) (City) (State)

Number of adults in apartment: _____ Number of children in apartment: _____

List of people in apartment:

_____

_____

_____

Occupancy date: _____ Security Deposit: Amount: $ _____ Date paid: _____

Rent amount: _____; Paid: ❑ monthly ❑weekly ❑other _____;

Payment type: ❑ Cash ❑ Personal Check ❑ 3rd Party Check ❑ Money Order ❑ Other_____

If subsidized rent, please list tenant portion: $_____

Rent Includes: ❑ All utilities ❑ No Utilities ❑ Hot Water ❑ Heat ❑ Electric

Type of Heat: ❑ Electric ❑ Oil ❑ Gas ❑ Other _____

Date last rent was paid: ____/____/____ Amount Paid: $_____

Payment type: ❑ Cash ❑ Personal Check ❑ 3rd Party Check ❑ Money Order ❑ Other_____

Back rent owed: $ _____ *(If back rent is owed, please attach accounting of months and amounts)*

For IRS reporting, landlord's Tax ID or Social Security # must be provided:

Tax ID #: _____ **OR** Social Security #: _____

Failure to provide the correct Tax ID or Social Security # may subject payments to backup withholding.

CHECK IS TO BE MADE PAYABLE TO*: (PLEASE PRINT)

_____ _____
Landlord's Name Telephone / Fax Numbers

_____
Landlord Address

_____
Name of Manager or other Representative

_____ _____
Landlord Signature Date

**Whenever the owner of property rented to a person receiving general assistance from the Town of Charlestown is in arrears in sewer, water, electricity, or tax payments to the Town of Charlestown, the Town of Charlestown may apply the assistance which the property owner would have received in payment of rent on behalf of such assisted person to the property owner's delinquent balances, regardless of whether such delinquent balances are in respect of property occupied by the assisted person. RSA 165:4-a.*

TOWN OF CHARLESTOWN, NH • DEPARTMENT OF HEALTH AND HUMAN SERVICES
P. O. Box 385, Charlestown, NH 03603
Telephone: (603) 826-5266 • Fax: (603) 826-5181

CHARLESTOWN, NEW HAMPSHIRE

EMPLOYMENT VERIFICATION FORM

This form is to be completed by the employer / former employer or it shall not be accepted as valid.

NAME OF EMPLOYEE: _____ SS#: _____-____-_____

EMPLOYER NAME: _____
ADDRESS: _____
_____

PHONE: _____ FAX: _____

I, _____, authorize the release of information regarding my employment to the Town of Charlestown Health and Human Service Office.

Signature: _____

STARTING DATE OF EMPLOYMENT: _____ HOURLY PAY RATE: _____
____ FULL-TIME POSITION ____ PART-TIME POSITION # HRS/WK _____
____ TEMPORARY POSITION (Please indicate time frame expected to work: _____)
FREQUENCY OF PAY (*please check one*): ___WEEKLY ___ BI-WEEKLY ___ OTHER: _____

PLEASE LIST THE LAST FOUR (4) PAY PERIODS AND AMOUNTS OF **NET** PAY:
DATE: _____ AMOUNT: $_____
DATE: _____ AMOUNT: $_____
DATE: _____ AMOUNT: $_____
DATE: _____ AMOUNT: $_____
DIRECT DEPOSIT (*please check one*): ___ YES ___ NO

EMPLOYMENT STATUS:
____ STILL EMPLOYED
____ TERMINATION / SEPARATION
If termination/separation, please indicate date of last employment: _____
If termination/separation, please indicate reason for termination/separation:
____ LAY OFF ____ TEMPORARY LEAVE (Medical or other personal leave)
____ VOLUNTARY RESIGNATION ____ RETIRED
____ DISMISSED WITH CAUSE ____ OTHER: _____

DOES THIS EMPLOYEE RECEIVE ANY OF THE FOLLOWING THROUGH EMPLOYER:
____ CREDIT UNION ACCT ____ SICK PAY ____ MEDICAL INSURANCE
____ LIFE INSURANCE ____ RETIREMENT PLAN (i.e.: 401K, IRA, etc.)
____ SHORT-TERM DISABILITY ____ LONG-TERM DISABILITY

_____ _____
Authorized company signature Print name

_____ _____ _____
Phone # E-mail Date

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AUTHORIZATION TO RELEASE INFORMATION

(*Charlestown, New Hampshire*—**APPLICANT ONLY**)

I, _____ of the town of Charlestown, New Hampshire, County of Sullivan, being an applicant for Town Assistance under the laws of the State of New Hampshire, RSA 165 *et seq.*, hereby authorize and request any relative, health care provider, banker, financial firm or organization, fiscal officer, police officer, parole officer, employer, utility company, fraternal order, Social Security Office, Church, minister, priest, State or local welfare department or human services department, local or regional community action program (CAP), shelter program, or any other person, firm, association, or organization having any information concerning my circumstances as they may relate to eligibility for Town Assistance to furnish such information to the *Welfare Official* of Charlestown, New Hampshire. I also authorize the *Welfare Official* of Charlestown, New Hampshire to release information to other Welfare and Social Service agencies, or any other person, firm, association, or organization involved in the servicing of my case. A photocopy or facsimile of this release may be used in place of the original.

By signing below, I, _____, indicate that I have: (1) read this authorization; and (2) approved this authorization.

_____ _____
Signature *Date*

_____ _____
Social Security Number *Date of Birth*

_____
Address

_____/_____
Charlestown Welfare Official's Printed Name / *Signature of Charlestown Welfare Official*

CO-APPLICANT ONLY

AUTHORIZATION TO RELEASE INFORMATION

(*Charlestown, New Hampshire*—**CO-APPLICANT ONLY**)

I, _____ of the town of Charlestown, New Hampshire, County of Sullivan, being an applicant for Town Assistance under the laws of the State of New Hampshire, RSA 165 *et seq.*, hereby authorize and request any relative, health care provider, banker, financial firm or organization, fiscal officer, police officer, parole officer, employer, utility company, fraternal order, Social Security Office, Church, minister, priest, State or local welfare department or human services department, local or regional community action program (CAP), shelter program, or any other person, firm, association, or organization having any information concerning my circumstances as they may relate to eligibility for Town Assistance to furnish such information to the *Welfare Official* of Charlestown, New Hampshire. I also authorize the *Welfare Official* of Charlestown, New Hampshire to release information to other Welfare and Social Service agencies, or any other person, firm, association, or organization involved in the servicing of my case. A photocopy or facsimile of this release may be used in place of the original.

By signing below, I, _____, indicate that I have: (1) read this authorization; and (2) approved this authorization.

_____ _____
Signature *Date*

_____ _____
Social Security Number *Date of Birth*

_____
Address

_____/_____
Charlestown Welfare Official's Printed Name / *Signature of Charlestown Welfare Official*

TOWN OF CHARLESTOWN, NH • DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FINANCIAL STATEMENT & DISCLOSURE

Pursuant to RSA 165:19

NAME_____

SPOUSE_____

ADDRESS_____

DEPENDENTS:_____ AGE _____

_____ AGE _____

_____ AGE _____

_____ AGE _____

HOUSEHOLD INCOME AND ASSETS

GROSS MONTHLY INCOME: $_____ NET MONTHLY INCOME $_____

TOTAL INCOME LAST YEAR $_____ SOURCE(S)_____

SAVINGS ACCOUNT BAL $_____ CHECKING ACCOUNT BAL $_____

STOCKS, BONDS, CD $_____ OTHER $_____

REAL OR PERSONAL PROPERTY _____

FOOD STAMPS $_____ CHILD SUPPORT $_____ PER_____

MONTHLY HOUSEHOLD EXPENSES *(Please list out of pocket expenses only):*

CABLE/INTERNET $_____ CHILD SUPPORT PAID $_____ CAR GASOLINE $_____

CAR INSURANCE $_____ CAR PAYMENT $_____ CHILD CARE $_____

CREDIT CARD $_____ ELECTRIC $_____ FOOD $_____

FUEL OIL $_____ GAS, NATURAL$_____ HEALTH INS $_____

LIFE INS $_____ LOAN $_____ LOT RENT $_____

MORTGAGE $_____ PRESCRIPTIONS $_____ RENT $_____

STUDENT LOAN $_____ TELEPHONE $_____ HOME/RENTER INS $_____

MEDICAL$_____ PROPERTY TAX $_____ WATER/SEWER $_____

OTHER_____

TOTAL MONTHLY INCOME : $_____ TOTAL MONTHLY EXPENSES : $_____

I have read, and I understand the attached RSA 165:19.

_____ _____

Signature *Date* *Signature* *Date*

Charlestown Town Assistance Office • 26 Railroad Street/P.O. Box 385 • Charlestown, NH 03603
Telephone (603) 826-5266 • Facsimile (603) 826-5181

CHARLESTOWN, NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES

APPLICATION FOR ASSISTANCE

Date of Application _____ Referred by _____

1. **General Information:**

Name _____ Date of Birth _____

Address _____

Telephone(H) _____ (W) _____ (C) _____

Social Security number _____-_____-_____ US Citizen? _____

Marital Status _____ Rent or Own? _____ How long at this address? _____

Spouse/Co-Applicant Name _____ SS# _____

Spouse address (if not same as applicant) _____

Assistance Requested _____

Reason for request _____

Have you applied for local assistance before? _____ When? _____

Where? _____ Under what name? _____

List below all persons living in your household:

Full Name	Relationship	Date of Birth	Social Security #

If at your current address less than 12 months, please list past 12 month's addresses:

Street	Town/City	State	Dates of Residence

2. Housing Information:

Rent amount _____ per (month/week) _____ Date last paid _____ Date due _____

Do you have a current: ☐ Demand For Rent ☐ Notice to Quit ☐ Landlord/Tenant Writ

Total rent owed _____ Do you have a housing subsidy? _____

Utilities Included: ☐ Heat ☐ Electric ☐ Gas ☐ Water/Sewer ☐ Other

LANDLORD: Name _____ Telephone _____

Address _____

IF HOME-OWNER: Mortgage Amount _____ Date last paid _____ Owed _____

Bank/Mortgage Co _____ Address _____

3. Education / Training / Employment

	Highest Grade Attended	G.E.D. or Diploma	Special Training or Skills	Military Service
Applicant:				
Spouse/Co-Applicant:				

Applicant Work History:

Are you employed now? _____ Employer _____ Position _____

When began work _____ Date/Amount of most recent check _____

Are you unemployed now? _____ Reason _____

Date last worked _____ Employer _____ Date/Amount last check _____

Are you able to work now? _____ If not able, why not? _____

Current and two most recent jobs of yourself and all household members aged 18 & older:

Name	Employer	Pay	Weekly/ Biweekly	Employment Dates	Reason for Leaving

4. Household Assets:

5. Household Income

Indicate any benefits or income received or applied for by you or any household member:

	Name	Date Applied	Date Last Received	Monthly Amount
ANB (Aid to the Needy Blind)				
APTD				
Child Support				
Disability (Employer)				
Food Stamps				
Fuel Assistance				
Gifts/Loans				
Maternity Benefits				
Medicaid				
OAA (Old Age Assistance)				
Retirement				
Severance Pay				
Social Security				
SSDI (SS Disability)				
SSI (Supplemental Security)				
TANF				
Unemployment				
Vacation Pay				
Veteran's Pension				
Vocational Rehabilitation				
WIC(Women/Infants/Children)				
Worker's Compensation				
Other: [ ]				

Are you or any other household member working, volunteering, and/or receiving assistance from any other agencies?

Name	Agency Name	Contact Person

TITLE XII
PUBLIC SAFETY AND WELFARE

CHAPTER 165
AID TO ASSISTED PERSONS

Liability for Support, and Recovery Over

Section 165:19

165:19 Liability for Support. – The relation of any poor person in the line of father, mother, stepfather, stepmother, son, daughter, husband, or wife shall assist or maintain such person when in need of relief. Said relation shall be deemed able to assist such person if his weekly income is more than sufficient to provide a reasonable subsistence compatible with decency and health. Should a relation refuse to render such aid when requested to do so by a county commissioner, selectman, or overseer of public welfare, such person or persons shall upon complaint of one of these officials be summoned to appear in court. If, after hearing, it is found that the alleged poor person is in need of assistance, and that the relation is able to render such assistance, the court shall enter a decree accordingly and shall fix the amount and character of the assistance, which the relation shall furnish. If the relation neglects or refuses to comply with the court order without good cause, as determined by the court at a hearing, or by refusing to work or otherwise voluntarily places himself in a position where he is unable to comply, he shall be deemed to be in contempt of court and shall be imprisoned not more than 90 nor fewer than 60 days. If a poor person has no relation of sufficient ability, the town or city in which he resides shall be liable for his support.

Source. RS 66:8. CS 70:8. GS 74:8. GL 82:8. PS 84:12. 1925, 112:1. PL 106:22. 1933, 65:1. RL 124:18. RSA 165:19. 1973, 115:1. 1985, 380:11, eff. Jan. 1, 1986.

Relatives are responsible for your assistance -- <u>before the town.</u>

Applicants can be asked to justify what support relatives are supplying, and/or justify why assistance is not being provided. This may require financial information from relatives.

Charlestown Department of Health & Human Services
P.O. Box 385 • Charlestown, NH 03603